Students: Talk to your Counselors about authorized spending money.

RCBs: Per Rehab contract: Please authorize $125.00 for spending money for client.

If student is under 18, we will need a parent signature to allow CSB staff to take pictures of your son/daughter involved in STEP activities.

The California School for the Blind staff has permission to take pictures of

_____ engaged in education and social activities during the STEP program 2017

_____
Parent (if student under 18 years of age)

_____
18 years/over signature

Applications are due by **May 29, 2017**

Acceptance will be announced by June 5, 2017

Please attach a one page letter explaining why you want to attend the Summer Transition Education Program and something about yourself.

Additional Comments from VI teacher or RCB:

_____

Rehabilitation Counselor's Signature

_____

Rehabilitation Counselor's Address/City (include zip code)

_____

Rehabilitation Counselor's Phone Number

_____

Rehabilitation Counselor's E-mail address

Return your completed application and letter to:

California School for the Blind
Attn: Ann Linville, Director of Transition
500 Walnut Avenue
Fremont, CA 94536

Any questions: (510) 794-3800
(510) 794-3850 (fax)
alinville@csb-cde.ca.gov (e-mail)

Students residing in the Apartment Living Program while attending STEP may ask permission to take oral medication and/or nasal inhalants independently.

Students taking injections regularly can apply for permission to self administer injections. The following steps are required:

- Talk with personal physician regarding procedure
- Ask personal physician or nurse to go through steps of preparation and injection
- Demonstrate steps to SHU nurse
- ALP staff member will observe procedure
- Student will log self-medication of oral and nasal medications

Tom Torlakson
State Superintendent of
Public Instruction

I, _____, requesting permission to assume responsibility for taking oral medication and/or nasal inhalant in my apartment. Responsibility for said medication will be mine.

All other types of medication are to be referred to the Health Service Facility.
A chart noting the taking of listed medication will be kept in the Apartment Staff Office.

_____	_____	_____
Signature of Student	Date	Apt. #

_____	_____
Signature of Parent (notes acknowledgement)	Date

Physician's permission and/or comments:

_____ has my permission to take responsibility for taking of the following medications/procedures:

_____	_____	_____
Physician's signature	License #	Office Phone #

Signatures below note acknowledgement:

_____	_____	_____
SHU Nurse Supervisor Student Health Service	Sharon Sacks Superintendent	Ann Linville Director Transition Services

Sincerely,

Ann Linville, Administrator